Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2789AGC	A. BUILDING _____ B. WING _____	04/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAWN GARDEN HOME CARE	9190 DAWN GARDEN AVE LAS VEGAS, NV 89147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 4/22/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a grade of A. The following deficiency was identified:	Y 000		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on record review on 4/22/09, the facility did not ensure 2 of 3 employees had evidence of FBI and State background check results in their files (Employee #1 fingerprints taken 1/6/09, and #3 fingerprints taken 2/12/08 and 2/16/09). This was a repeat deficiency from the 2/26/09 annual State Licensure survey. Severity: 2 Scope: 3	Y 105		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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